TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Mathew Loewen, D.O.

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-17-2112-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The examination for MMI/IR is reimbursed at **$350.00 and $150.00 for one body area** (DRE) method."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2016	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service.

Issues

1. Did American Zurich Insurance Company (Zurich) respond to the medical fee dispute?
2. Is Zurich's denial of payment for the disputed services supported?
3. Is Mathew Loewen, D.O. entitled to reimbursement of the disputed services?

Findings

1. The Austin carrier representative for Zurich is Flahive, Ogden & Latson. Flahive, Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on March 22, 2017.

   28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received on behalf of Zurich from Flahive, Ogden & Latson to date. The division concludes that Zurich failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Dr. Loewen is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on October 6, 2016. Per the submitted explanation of benefits dated December 10, 2016, Zurich denied the disputed services with claim adjustment reason code 18 – "EXACT DUPLICATE CLAIM/SERVICE."

   Review of the submitted documentation finds no evidence that the claim or service in dispute was a duplicate. No other denial reasons were presented. Zurich's denial of payment for the disputed services is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Loewen performed an evaluation of Maximum Medical Improvement. Therefore, the reimbursement for this examination is $350.00.

   Per 28 Texas Administrative Code §134.250(4), "The following applies for billing and reimbursement of an IR evaluation… (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used." The submitted documentation supports that Dr. Loewen performed an evaluation to determine the impairment rating of the lumbar spine using the DRE method found in the AMA Guides 4th edition. Therefore, the reimbursement for this examination is $150.00.

   The total allowable for the disputed services is $500.00. Dr. Loewen is seeking $150.00. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	June 23, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.